



Testimony

Before the Subcommittee on National
Security and Foreign Affairs, Committee
on Oversight and Government Reform,
House of Representatives

For Release on Delivery
Expected 2:00 p.m. EST
Wednesday, February 27, 2008

DOD AND VA

Preliminary Observations on Efforts to Improve Care Management and Disability Evaluations for Servicemembers

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Report Documentation Page				Form Approved OMB No. 0704-0188	
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE 27 FEB 2008		2. REPORT TYPE		3. DATES COVERED 00-00-2008 to 00-00-2008	
4. TITLE AND SUBTITLE DOD and VA. Preliminary Observations on Efforts to Improve Care Management and Disability Evaluations for Servicemembers				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) U.S. General Accountability Office, 441 G Street NW, Washington, DC, 20548				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT Same as Report (SAR)	18. NUMBER OF PAGES 29	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

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Highlights

Highlights of [GAO-08-514T](#), a testimony before the Subcommittee on National Security and Foreign Affairs, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

In February 2007, a series of *Washington Post* articles about conditions at Walter Reed Army Medical Center highlighted problems in the Army's case management of injured servicemembers and in the military's disability evaluation system. These deficiencies included a confusing disability evaluation process and servicemembers in outpatient status for months and sometimes years without a clear understanding about their plan of care. These reported problems prompted various reviews and commissions to examine the care and services to servicemembers. In response to problems at Walter Reed and subsequent recommendations, the Army took a number of actions and DOD formed a joint DOD-VA Senior Oversight Committee.

This statement updates GAO's September 2007 testimony and is based on ongoing work to (1) assess actions taken by the Army to help ill and injured soldiers obtain health care and navigate its disability evaluation process; and to (2) describe the status, plans, and challenges of DOD and VA efforts to implement a joint disability evaluation system. GAO's observations are based largely on documents obtained from and interviews with Army, DOD, and VA officials. The facts contained in this statement were discussed with representatives from the Army, DOD, and VA.

To view the full product, including the scope and methodology, click on [GAO-08-514T](#). For more information, contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov; or John H. Pendleton at (202) 512-7114 or pendletonj@gao.gov.

DOD AND VA

Preliminary Observations on Efforts to Improve Care Management and Disability Evaluations for Servicemembers

What GAO Found

Over the past year, the Army significantly increased support for servicemembers undergoing medical treatment and disability evaluations, but challenges remain. To provide a more integrated continuum of care for servicemembers, the Army created a new organizational structure—the Warrior Transition Unit—in which servicemembers are assigned key staff to help manage their recovery. Although the Army has made significant progress in staffing these units, several challenges remain, including hiring medical staff in a competitive market, replacing temporarily borrowed personnel with permanent staff, and getting eligible servicemembers into the units. To help servicemembers navigate the disability evaluation process, the Army is increasing staff in several areas, but gaps and challenges remain. For example, the Army expanded hiring of board liaisons to meet its goal of 30 servicemembers per liaison, but as of February 2008, the Army did not meet this goal at 11 locations that support about half of servicemembers in the process. The Army faces challenges hiring enough liaisons to meet its goals and enough legal personnel to help servicemembers earlier in the process.

To address more systemic issues, DOD and VA promptly designed and are now piloting a streamlined disability evaluation process. In August 2007, DOD and VA conducted an intensive 5-day exercise that simulated alternative pilot approaches using previously-decided cases. This exercise yielded data quickly, but there were trade-offs in the nature and extent of data that could be obtained in that time frame. The pilot began with “live” cases at three treatment facilities in the Washington, D.C. area in November 2007, and DOD and VA may consider expanding the pilot to additional sites around July 2008. However, DOD and VA have not finalized their criteria for expanding the pilot beyond the original sites and may have limited pilot results at that time. Significantly, current evaluation plans lack key elements, such as an approach for measuring the performance of the pilot—in terms of timeliness and accuracy of decisions—against the current process, which would help planners manage for success of further expansion.

Major Differences between Current and Pilot Military Disability Evaluation Processes

	Current process	Pilot process
Servicemember	Board liaison provides support	Board liaison and VA staff provide support
	Medical Evaluation Board (MEB) Physical performed by military department	Medical Evaluation Board (MEB) Comprehensive physical performed to VA standards
Separation	Physical Evaluation Board (PEB) Military department determines disability rating for computing DOD disability benefits	Physical Evaluation Board (PEB) VA determines disability rating used for computing DOD disability benefits
	Receives DOD disability benefits AND Develops claim for VA disability benefits – Comprehensive physical performed to VA standards – VA determines disability rating	Receives DOD disability benefits AND Receives VA disability benefits shortly after leaving military
Veteran		

Source: GAO analysis of DOD documents.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as you examine issues related to meeting the critical needs of returning wounded warriors. At present, over 30,000 servicemembers have been wounded in Operations Enduring Freedom and Iraqi Freedom.¹ Due to improved battlefield medicine, those who might have died in past conflicts are now surviving, many with multiple serious injuries such as amputations, traumatic brain injury (TBI), and post-traumatic stress disorder (PTSD). Beyond adjusting to their injuries, returning servicemembers can face additional challenges within the military. In February 2007, a series of *Washington Post* articles about conditions at Walter Reed Army Medical Center highlighted problems in the Army's management of care for injured servicemembers and in the military's disability evaluation system.

Since that time, various reviews and high-level commissions have identified substantial weaknesses in the care that servicemembers receive and the disability evaluation systems that they must navigate. For example, in March 2007, the Army Inspector General identified numerous issues with the Army's disability evaluation system and related care,² including a failure to meet timeliness standards for determinations, inadequate training of staff, and the lack of standardized operations and structure to care for returning servicemembers. Similarly, reports from several commissions highlighted long delays and confusion that ill or injured servicemembers experience as they navigate the military disability evaluation system, and their distrust of a process perceived to be adversarial.³ The commissions referred to prior GAO work, including a March 2006 report in which GAO found that the services were not meeting Department of Defense (DOD) timeliness goals for processing disability

¹The data include Active, Reserve, and National Guard servicemembers wounded in action from October 7, 2001, to February 2, 2008. Over two-thirds of these servicemembers are in the Army.

²Office of the Inspector General, Department of the Army, *Report on the Army Physical Disability Evaluation System* (Washington, D.C.: Mar. 6, 2007).

³Independent Review Group, *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (Arlington, Va.: Apr. 2007); Task Force on Returning Global War on Terror Heroes, *Report to the President* (April 2007); President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify* (July 2007).

cases and that neither DOD nor the services systematically evaluated the consistency of disability decisions.⁴ In October 2007, the Veterans' Disability Benefits Commission reported significant differences in disability ratings between DOD and the Department of Veterans Affairs (VA)—with VA often assigning higher ratings than DOD.⁵

In response to the deficiencies reported by the media, the Army took several actions including, most notably, initiating the development of the Army Medical Action Plan in March 2007. The plan, designed to help the Army become more patient-focused, includes tasks for establishing a continuum of care and service, automating portions of the disability evaluation system, and maximizing coordination of efforts with VA.

In May 2007, DOD established the Wounded, Ill, and Injured Senior Oversight Committee (Senior Oversight Committee) to bring high-level attention to addressing the problems associated with the care and treatment of returning servicemembers. The committee is co-chaired by the Deputy Secretaries of Defense and Veterans Affairs and also includes the military service secretaries and other high-ranking officials within DOD and VA. To conduct its work, the Senior Oversight Committee established workgroups that have focused on specific areas including the disability evaluation system. In particular, under the direction of the Senior Oversight Committee, DOD and VA are piloting a joint disability evaluation system.

In September 2007, we testified before this subcommittee on our preliminary observations with respect to Army, DOD, and VA efforts to improve health care and disability evaluations for servicemembers.⁶ Our testimony today provides an update on these efforts and focuses on our ongoing work to (1) assess actions taken by the Army to help ill and injured soldiers obtain health care and navigate its disability evaluation process, and (2) describe the status, plans, and challenges of DOD's and

⁴GAO, *Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members*, [GAO-06-362](#) (Washington, D.C.: Mar. 31, 2006).

⁵Veterans' Disability Benefits Commission, *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century* (October 2007).

⁶GAO, *DOD and VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers*, [GAO-07-1256T](#) (Washington, D.C.: Sept. 26, 2007).

VA's efforts to implement a joint disability evaluation system. Our testimony is based on documents obtained from and interviews with Army, DOD, and VA officials. Specifically, we reviewed staffing data related to case management and disability evaluation initiatives established in the Army Medical Action Plan. We did not verify the accuracy of these data; however, we interviewed agency officials knowledgeable about the data, and we determined that they were sufficiently reliable for the purposes of this statement. We visited several Army sites—Walter Reed Army Medical Center (Washington, D.C.), Forts Sam Houston and Hood (Texas), Fort Lewis (Washington), and Forts Benning and Gordon (Georgia)—to talk with Army officials about efforts to improve the health care and the disability evaluation system for servicemembers and obtain views from servicemembers about how these efforts are affecting them. In addition, we reviewed the results of Army efforts to obtain servicemembers' opinions about the Warrior Transition Unit and the disability evaluation process. We also spoke with officials from DOD and VA to learn about their plans for implementing and evaluating the disability evaluation pilot. Our findings are preliminary. It was beyond the scope of our work for this statement to review the efforts underway in other military services. We discussed the facts contained in this statement with Army officials, and we incorporated their comments where appropriate. Our work, which began in July 2007, is being conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, the Army continues to increase support to servicemembers undergoing medical treatment and disability evaluations, but faces challenges reaching or maintaining its goals. To provide a more integrated continuum of care for servicemembers, the Army has developed a new organizational structure called Warrior Transition Units. Within each unit, a servicemember is assigned to a team of three key staff—a primary care manager, a nurse case manager, and a squad leader—who manage the servicemember's care. Since September 2007, the Army has made considerable progress in staffing this structure, increasing the number of staff assigned to key positions by almost 75 percent. However, shortfalls continue to exist in some areas—11 of the 32 U.S. Warrior Transition Units had less than 90 percent of needed staff for one or more key positions. In addition, the Army is facing other challenges, which include replacing borrowed staff in key positions with permanently assigned staff without

disrupting the continuity of care for servicemembers and moving additional eligible servicemembers into the units without exacerbating existing staff shortfalls in some locations. Furthermore, another emerging challenge is the Army's ability to gather reliable and objective data on how well the units are meeting servicemembers' needs.

Some servicemembers may not recover sufficiently to return to duty. To support servicemembers who must undergo a fitness for duty assessment and disability evaluation, the Army is reducing caseloads and expanding hiring of key staff responsible for helping servicemembers navigate the process. For example, for evaluation board liaisons who help servicemembers track the process, the Army established an average caseload goal of 30 servicemembers per board liaison and hired more board liaisons to help meet this goal. However, almost one-third of treatment locations—which support about half of servicemembers in the disability evaluation process—have not met this goal. In addition, the Army assigned 18 additional legal staff to support the disability evaluation process in June 2007; however, current staffing levels are still insufficient for widespread legal support early in the process. The Army has other efforts underway to improve servicemembers' ability to navigate the disability process, such as conducting standardized briefings about the evaluation process, but reliable data on the effectiveness of these and other efforts are not yet available.

To address issues with both DOD and VA disability evaluations, including untimely and inconsistent decisions and servicemember frustration, the agencies have designed, and are piloting, a streamlined disability evaluation process. DOD and VA moved quickly to design and implement the pilot for eventual expansion to all servicemembers. To obtain the data for determining the pilot design and supporting the implementation decision, DOD and VA conducted an intensive 5-day exercise that simulated four alternative pilot approaches using previously-decided cases. While the simulation was a formal exercise and yielded useful information, the short time frames necessitated trade-offs between moving quickly and doing a more thorough evaluation, such as using a small number of cases instead of a larger number that better represented the relative workloads of the military services. DOD and VA began "live" implementation of the pilot—using actual cases—at three treatment facilities in the Washington, D.C. area in November 2007. DOD and VA may consider expanding the pilot to a few sites outside the Washington, D.C. area around July 2008, but have yet to finalize their criteria for expanding implementation beyond the original sites. Further, some key metrics, such as the timeliness and accuracy of final DOD and VA decisions, might lag

behind expansion time frames and dates for reporting on pilot progress to Congress. To date, DOD's and VA's pilot evaluation plan lacks key elements, such as an approach for measuring the performance of the pilot—for example, in terms of timeliness, accuracy, and consistency of decisions—against the current process, and for surveying and measuring satisfaction of pilot participants.

Background

DOD and VA offer health care benefits to active duty servicemembers and veterans, among others. Under DOD's health care system, eligible beneficiaries may receive care from military treatment facilities or from civilian providers. Military treatment facilities are individually managed by each of the military services—the Army, the Navy,⁷ and the Air Force. Under VA, eligible beneficiaries may obtain care through VA's integrated health care system of hospitals, ambulatory clinics, nursing homes, residential rehabilitation treatment programs, and readjustment counseling centers. VA has organized its health care facilities into a polytrauma system of care⁸ that helps address the medical needs of returning servicemembers and veterans, in particular those who have an injury to more than one part of the body or organ system that results in functional disability and physical, cognitive, psychosocial, or psychological impairment. Persons with polytraumatic injuries may have injuries or conditions such as TBI, amputations, fractures, and burns.

Over the past 6 years, DOD has designated over 30,000 servicemembers involved in Operations Iraqi Freedom and Enduring Freedom as wounded in action. Servicemembers injured in these conflicts are surviving injuries that would have been fatal in past conflicts, due, in part, to advanced protective equipment and medical treatment. The severity of their injuries can result in a lengthy transition from patient back to duty, or to veteran status. Initially, most seriously injured servicemembers from these conflicts, including activated National Guard and Reserve members, are evacuated to Landstuhl Regional Medical Center in Germany for treatment. From there, they are usually transported to military treatment facilities in the United States, with most of the seriously injured admitted to Walter Reed Army Medical Center or the National Naval Medical Center. According to DOD officials, once they are stabilized and discharged from

⁷The Navy is responsible for the medical care of servicemembers in the Marine Corps.

⁸The system is composed of categories of medical facilities that offer varying levels of services.

the hospital, servicemembers may relocate closer to their homes or military bases and are treated as outpatients by the closest military or VA facility.

As part of the Army's Medical Action Plan, the Army has developed a new organizational structure—Warrior Transition Units—for providing an integrated continuum of care for servicemembers who generally require at least 6 months of treatment, among other factors. Within each unit, the servicemember is assigned to a team of three key staff and this team is responsible for overseeing the continuum of care for the servicemember.⁹ The Army refers to this team as a “Triad,” which consists of a (1) primary care manager—usually a physician who provides primary oversight and continuity of health care and ensures the quality of the servicemember's care; (2) nurse case manager—usually a registered nurse who plans, implements, coordinates, monitors, and evaluates options and services to meet the servicemember's needs; and (3) squad leader—a noncommissioned officer who links the servicemember to the chain of command, builds a relationship with the servicemember, and works along side the other parts of the Triad to ensure the needs of the servicemember and his or her family are met. The Army established 32 Warrior Transition Units, to provide a unit in every medical treatment facility that has 35 or more eligible servicemembers.¹⁰ The Army's goal is to fill the Triad positions according to the following ratios: 1:200 for primary care managers; 1:18 for nurse case managers at Army medical centers that normally see servicemembers with more acute conditions and 1:36 for other types of Army medical treatment facilities; and 1:12 for squad leaders.

Returning injured servicemembers must potentially navigate two different disability evaluation systems that generally rely on the same criteria but for different purposes. DOD's system serves a personnel management purpose by identifying servicemembers who are no longer medically fit for duty. The military's process starts with identification of a medical condition that could render the servicemember unfit for duty, a process that could take months to complete. The servicemember is evaluated by a medical evaluation board (MEB) to identify any medical conditions that may render the servicemember unfit. The member is then evaluated by a

⁹The Warrior Transition Unit also includes other staff, such as human resources and financial management specialists.

¹⁰The Army also established three Warrior Transition Units in Germany.

physical evaluation board (PEB) to make a determination of fitness or unfitness for duty. If found unfit, and the unfit conditions were incurred in the line of duty, the PEB assigns the servicemember a combined percentage rating for those unfit conditions using VA's rating system as a guideline, and the servicemember is discharged from duty. This disability rating, along with years of service and other factors, determines subsequent disability and health care benefits from DOD.¹¹ For servicemembers meeting the minimum rating and years of duty thresholds, monthly disability retirement payments are provided; for those not meeting these thresholds, a lump-sum severance payment is provided.

As servicemembers in the Army navigate DOD's disability evaluation system, they interface with staff who play a key role in supporting them through the process. MEB physicians play a fundamental role as they are responsible for documenting the medical conditions of servicemembers for the disability evaluation case file. In addition, MEB physicians may require that servicemembers obtain additional medical evidence from specialty physicians such as a psychiatrist. Throughout the MEB and PEB process, a physical evaluation board liaison officer serves a key role by explaining the process to servicemembers, and ensuring that the servicemembers' case files are complete before they are forwarded for adjudication. The board liaison officer informs servicemembers of board results and of deadlines at key decision points in the process. The military also provides legal counsel to servicemembers in the disability evaluation process. The Army, for example, provides them with legal representation at formal board hearings. The Army will provide military counsel, or servicemembers may retain their own representative at their own expense.

In addition to receiving benefits from DOD, veterans may receive compensation from VA for lost earning capacity due to service-connected disabilities. Although a servicemember may file a VA claim while still in the military, he or she can only obtain disability compensation from VA as a veteran. VA will evaluate all claimed conditions, whether they were evaluated previously by the military service's evaluation process or not. If the VA finds that a veteran has one or more service-connected disabilities with a combined rating of at least 10 percent,¹² VA will pay monthly

¹¹Servicemembers who separate from the military with a DOD disability rating of 30 percent or higher receive health care benefits for life regardless of years of service.

¹²VA determines the degree to which veterans are disabled in 10 percent increments on a scale of 0 to 100 percent.

compensation. The veteran can claim additional benefits over time, for example, if a service-connected disability worsens.

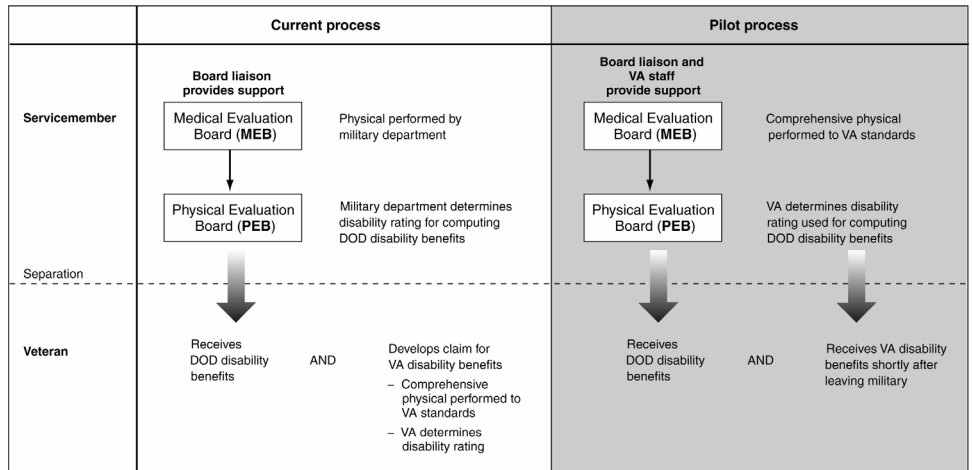
To improve the timeliness and resource utilization of DOD's and VA's separate disability evaluation systems, the agencies embarked on a planning effort of a joint disability evaluation system that would enable servicemembers to receive VA disability benefits shortly after leaving the military without going through both DOD's and VA's processes. A key part of this planning effort included a "table top" exercise whereby the planners simulated the outcomes of cases using four potential options that incorporated variations of following three elements: (1) a single, comprehensive medical examination to be used by both DOD and VA in their disability evaluations; (2) a single disability rating performed by VA; and (3) incorporating a DOD-level evaluation board for adjudicating servicemembers' fitness for duty. Based on the results of this exercise, DOD and VA implemented the selected pilot design using live cases at three Washington, D.C.-area military treatment facilities including Walter Reed Army Medical Center in November 2007.¹³ Key features of the pilot include (see fig. 1):

- a single physical examination conducted to VA standards as part of the medical evaluation board;¹⁴
- disability ratings prepared by VA, for use by both DOD and VA in determining disability benefits; and
- additional outreach and non-clinical case management provided by VA staff at the DOD pilot locations to explain VA results and processes to servicemembers.

¹³The three pilot locations are Walter Reed Army Medical Center, Washington, D.C.; National Naval Medical Center, Bethesda, Maryland; and Malcolm Grow Air Force Medical Center, Andrews Air Force Base, Maryland.

¹⁴For the current pilot locations, examinations are conducted at the Washington, D.C., VA Medical Center.

Figure 1: Major Differences between Current and Pilot Military Disability Evaluation Processes



Source: GAO analysis of DOD documents.

The Army Continues to Increase Support to Servicemembers Undergoing Medical Treatment and Disability Evaluation, but Faces Challenges Reaching Stated Goals

The Army has made strides increasing key staff positions in support of servicemembers undergoing medical treatment as well as disability evaluation, but faces a number of challenges to achieving or maintaining stated goals. Although the Army has made significant progress in staffing its Warrior Transition Units, several challenges remain, including hiring medical staff in a competitive market, replacing temporarily borrowed personnel with permanent staff, and getting eligible servicemembers into the units. With respect to supporting servicemembers as they navigate the disability evaluation process, the Army has reduced caseloads of key support staff, but has not yet reached its goals and faces challenges with both hiring and meeting current demands of servicemembers in the process.

Army Has Made Considerable Progress in Staffing Its Warrior Transition Units, but Faces Shortfalls and Other Challenges

Since September 2007, the Army has made considerable progress in staffing its Warrior Transition Units, increasing the number of staff assigned to Triad positions by almost 75 percent. As of February 6, 2008, the Army had about 2,300 personnel staffing its Warrior Transition Units. In February 2008, the Army reported that its Warrior Transition Units had achieved “full operational capability,” which was the goal established in the Army’s Medical Action Plan. The Warrior Transition Units reported

that they had met this goal even though some units had staffing shortages or faced other challenges.¹⁵

Although encouraging, the Army is facing several challenges in fully staffing the Warrior Transition Units and ensuring all eligible servicemembers can benefit from the care provided in these units. For example, the Army established a goal of having at least 90 percent of Triad staff positions filled to meet the staff-to-servicemember ratios that the Army had established for its Warrior Transition Units.¹⁶ As of February 6, 2008, the Army had surpassed this goal for 21 of the 32 units. However, the remaining 11 Warrior Transition Units had less than 90 percent of needed staff for one or more Triad positions—representing a total shortfall of 10 primary care managers, 44 nurse case managers, and 10 squad leaders. (See table 1.) Although most of these locations were missing only 1 or 2 staff, a few locations had more significant shortfalls. For example, Fort Hood needed almost 30 nurse case managers to meet the Army's 90 percent goal. Army officials cited challenges in staffing Triad positions, including difficulties in hiring physicians and other medical personnel at certain locations because salary levels do not provide the necessary incentives in a competitive market

¹⁵The Army's January 2008 assessment defined full operational capability across a wide variety of areas identified in the Army's Medical Action Plan, not just personnel fill. For example, the assessment included whether facilities and barracks were suitable and whether a Soldier and Family Assistance Center was in place and providing essential services. In addition, the commander assessed whether the unit could conduct the mission-essential tasks assigned to it. As a result, such ratings have both objective and subjective elements, and the Army allows commanders to change the ratings based on their judgment.

¹⁶The ratios are 1:200 for primary care managers; 1:18 for nurse case managers at Army medical centers that normally see servicemembers with more acute conditions and 1:36 for other types of Army medical treatment facilities; and 1:12 for squad leaders.

Table 1: Locations Where Warrior Transition Units Had Less Than 90 Percent of Staff in Place in One or More Triad Positions, as of February 6, 2008.

Location (size of Warrior Transition Unit population)	Additional Triad staff needed ^a		
	Primary care managers	Nurse case managers	Squad leaders
Fort Hood, Texas (957)	2	28	2
Walter Reed Army Medical Center, Washington, D.C. (674)	1		
Fort Lewis, Washington (613)	3	10	
Fort Campbell, Kentucky (596)	1	1	
Fort Drum, New York (395)	1	1	5
Fort Polk, Louisiana (248)	1		
Fort Knox, Kentucky (243)	1		
Fort Irwin & Balboa, California (89)		2	1
Fort Belvoir, Virginia (43)		1	1
Fort Huachuca, Arizona (41)		1	
Redstone Arsenal, Alabama (17)			1
Total Staff Needed	10	44	10

Source: GAO analysis of Army data.

Note: The staffing needed is based on the number of servicemembers in each Warrior Transition Unit, as of February 6, 2008.

^aThe number of additional staff needed to achieve the Army's goal of filling 90 percent of Triad positions at each location.

The Army is confronting other challenges, as well, including replacing borrowed staff in Triad positions with permanently assigned staff without disrupting the continuity of care for servicemembers. We previously reported in September 2007 that many units were relying on borrowed staff to fill positions—about 20 percent overall. This practice has continued; in February 2008, about 20 percent of Warrior Transition Unit staff continued to be borrowed from other positions.¹⁷ Army officials told us that using borrowed staff was necessary to get the Warrior Transition

¹⁷These staff include the Triad—primary care managers, nurse case managers, and squad leaders—as well as other Warrior Transition staff such as platoon sergeants, behavioral health specialists, social workers, and administrative personnel.

Units implemented quickly and has been essential in staffing units that have experienced sudden increases in servicemembers needing care. Army officials told us that using borrowed staff is a temporary solution for staffing the units, and these staff will be transitioned out of the positions when permanent staff are available. Replacing the temporary staff will result in turnover among Warrior Transition Unit staff, which can disrupt the continuity of care provided to servicemembers.

Another lingering challenge facing the Army is getting eligible servicemembers into the Warrior Transition Units. In developing its approach, the Army envisioned that servicemembers meeting specific criteria, such as requiring more than 6 months of treatment or having a condition that requires going through the Medical Evaluation Board process, would be assigned to the Warrior Transition Units. Since September 2007, the Warrior Transition Unit population has increased by about 80 percent—from about 4,350 to about 7,900 servicemembers. However, although the percentage of eligible servicemembers going through the Medical Evaluation Board process who were not in a Warrior Transition Unit has been cut almost in half since September 2007, more than 2,500 eligible servicemembers were not in units, as of February 6, 2008. About 1,700 of these servicemembers (about 70 percent) are concentrated in ten locations. (See table 2.)

Table 2: Locations with 100 or More Eligible Servicemembers Not in a Warrior Transition Unit, as of February 6, 2008

Location	Total number of servicemembers eligible for a Warrior Transition Unit	Number of eligible servicemembers not in a Warrior Transition Unit	Percentage of total eligible servicemembers not in a Warrior Transition Unit
Fort Hood, Texas	1,331	374	28
Fort Carson, Colorado	603	240	40
Fort Bragg, North Carolina	666	199	30
Fort Gordon, Georgia	437	183	42
Fort Lewis, Washington	783	170	22
Fort Knox, Kentucky	359	116	32
Fort Campbell, Kentucky	711	115	16
Fort Drum, New York	500	105	21
West Point, New York	164	105	64
Tripler Army Medical Center, Hawaii	283	101	36
Total	5,837	1,708	29

Source: GAO analysis of Army data.

Warrior Transition Unit commanders conduct risk assessments of eligible servicemembers to determine if their care can be appropriately managed outside of the Warrior Transition Unit. These assessments are to be conducted within 30 days of determining that the servicemember meets eligibility criteria. For example, a servicemember's knee injury may require a Medical Evaluation Board review—a criterion for being placed in a Warrior Transition Unit—but the person's unit commander can determine that the person can perform a desk job while undergoing the medical evaluation process. According to Army guidance, servicemembers eligible for the Warrior Transition Unit will generally be moved into the units, that it will be the exception, not the rule, for a servicemember to not be transferred to a Warrior Transition Unit. Army officials told us that the population of 2,500 servicemembers who had not been moved into a Warrior Transition Unit consisted of both servicemembers who had just recently been identified as eligible for a unit but had not yet been evaluated and servicemembers whose risk assessment determined that their care could be managed outside of a unit. Officials told us that servicemembers who needed their care managed more intensively through Warrior Transition Units had been identified through the risk assessment process and had been moved into such units. As eligible personnel are brought into the Warrior Transition Units, however, it could exacerbate staffing shortfalls in some units. To minimize future staffing shortfalls, Army officials told us that they are identifying areas where they anticipate future increases in the number of servicemembers needing care in a Warrior Transition Unit and would use this information to determine appropriate future staffing needs of the units.

Another emerging challenge is gathering reliable and objective data to measure progress. A central goal of the Army's efforts is to make the system more servicemember- and family-focused and the Army has initiated efforts to determine how well the units are meeting servicemembers' needs. To its credit, the Army has developed a wide range of methods to monitor its units, among them a program to place independent ombudsmen throughout the system as well as town hall meetings and a telephone hotline for servicemembers to convey concerns about the Warrior Transition Units. Additionally, through its Warrior Transition Program Satisfaction Survey, the Army has been gathering and analyzing information on servicemembers' opinions about their nurse case manager and the overall Warrior Transition Unit. However, initial response rates have been low, which has limited the Army's ability to reliably assess satisfaction. In February 2008, the Army started following up with nonrespondents, and officials told us that these efforts have begun to improve response rates. To obtain feedback from a larger percentage of

servicemembers in the Warrior Transition Units, the Army administered another satisfaction survey in January 2008. This survey, which also solicited servicemembers' opinions about components of the Triad and overall satisfaction with the Warrior Transition Units, garnered a more than 90 percent response rate from the population surveyed.¹⁸ While responses to the survey were largely positive, the survey is limited in its ability to accurately gauge the Army's progress in improving servicemember satisfaction with the Warrior Transition Unit, because it was not intended to be a methodologically rigorous evaluation. For example, the units were not given specific instructions on how to administer the survey, and as a result, it is not clear the extent to which servicemembers were provided anonymity in responding to the survey. Units were instructed to reach as many servicemembers as possible within a 24-hour period in order to provide the Army with immediate feedback on servicemembers' overall impressions of the care they were receiving.

Despite Hiring Efforts, Army Faces Challenges Providing Sufficient Staff to Help Servicemembers Navigate the Disability Evaluation Process

Injured and ill servicemembers who must undergo a fitness for duty assessment and disability evaluation rely on the expertise and support of several key staff—board liaisons, legal personnel, and board physicians—to help them navigate the process. Board liaisons explain the disability process to servicemembers and are responsible for ensuring that their disability case files are complete. Legal staff and medical evaluation board physicians can substantially influence the outcome of servicemembers' disability evaluations because legal personnel provide important counsel to servicemembers during the disability evaluation process, and evaluation board physicians evaluate and document servicemembers' medical conditions for the disability evaluation case file.¹⁹

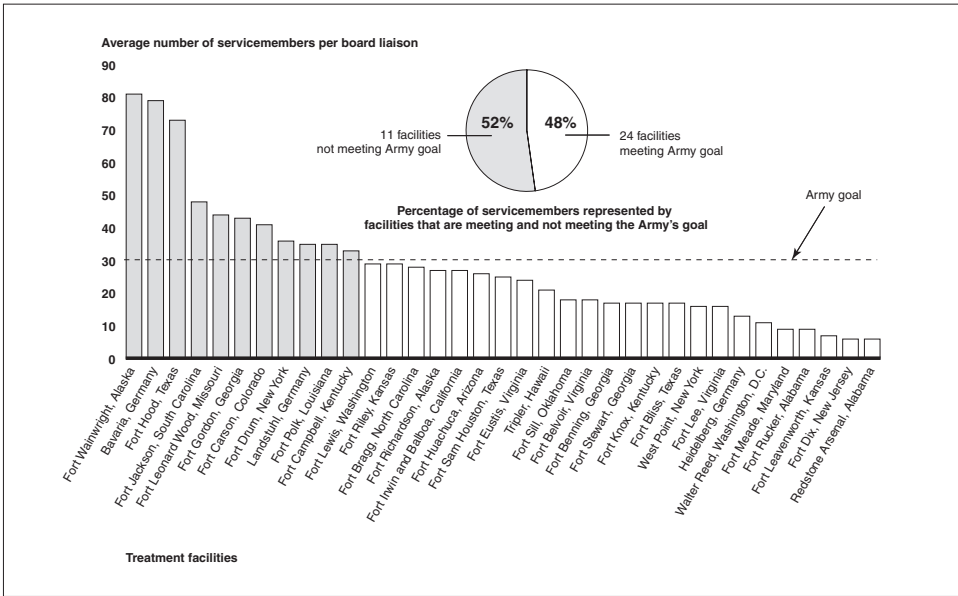
With respect to board liaisons, the Army has expanded hiring efforts and met its goals for reducing caseloads at most treatment facilities, but not at some of the facilities with the most servicemembers in the process. In

¹⁸The survey was distributed to 4,430 servicemembers, which represented about 60 percent of the total Warrior Transition Unit population at the time of the survey. Some servicemembers may not have received a survey because, according to an Army official, they were receiving care through a Community Based Health Care Organization, were on leave, or were undergoing treatment. Additionally, three units' survey responses were received too late to incorporate into the Army's analyses.

¹⁹Board physicians, unlike board liaisons and legal staff who are dedicated to serving servicemembers in the disability evaluation process, are part of the Warrior Transition Units.

August 2007, the Army established an average caseload target of 30 servicemembers per board liaison. As of February 2008, the Army had expanded the number of board liaisons by about 22 percent. According to the Army, average caseloads per liaison have declined from 54 servicemembers at the end of June 2007 to 46 at the end of December 2007. However, 11 of 35 treatment facilities continue to have shortages of board liaisons and about half of all servicemembers in the disability evaluation process are located at these 11 treatment facilities. (See fig. 2.) Due to their caseloads, liaisons we spoke with at one location had difficulty making appointments with servicemembers, which has challenged their ability to provide timely and comprehensive support.

Figure 2: Average Number of Servicemembers per Board Liaison at Treatment Facilities, February 6, 2008



Source: GAO analysis based on Army data.

The Army plans to hire additional board liaisons, but faces challenges in keeping up with increased demand. According to an Army official responsible for staff planning, the Army reviews the number of liaisons at each treatment facility weekly and reviews Army policy for the target number of servicemembers per liaison every 90 days. The official also identified several challenges in keeping up with increased demand for board liaisons, including the increase in the number of injured and ill servicemembers in the medical evaluation board process overall, and the difficulty of attracting and retaining liaisons at some locations. According

to Army data, the total number of servicemembers completing the medical evaluation board process increased about 19 percent from the end of 2006 to the end of 2007.

In addition to gaps in board liaisons, according to Army documents, staffing of dedicated legal personnel who provide counsel to injured and ill servicemembers throughout the disability evaluation processes is currently insufficient. Ideally, according to the Army, servicemembers should receive legal assistance during both the medical and physical evaluation board processes. While servicemembers may seek legal assistance at any time, the Office of the Judge Advocate General's policy is to assign dedicated legal staff to servicemembers when their case goes before a formal physical evaluation board. In June 2007, the Army assigned 18 additional legal staff—12 Reserve attorneys and 6 Reserve paralegals—to help meet increasing demands for legal support throughout the process. As of January 2008, the Army had 27 legal personnel—20 attorneys and 7 paralegals—located at 5 of 35 Army treatment facilities who were dedicated to supporting servicemembers primarily with the physical evaluation board process.²⁰ However, the Office of the Judge Advocate General has acknowledged that these current levels are insufficient for providing support during the medical evaluation board process, and proposed hiring an additional 57 attorneys and paralegals to provide legal support to servicemembers during the medical evaluation board process. The proposed 57 attorneys and paralegals include 19 active-duty military attorneys, 19 civilian attorneys, and 19 civilian paralegals. On February 21, 2008, Army officials told us that 30 civilian positions were approved, consisting of 15 attorneys and 15 paralegals.

While the Army has plans to address gaps in legal support for servicemembers, challenges with hiring and staff turnover could limit their efforts. According to Army officials, even if the plan to hire additional personnel is approved soon, hiring of civilian attorneys and paralegals may be slow due to the time it takes to hire qualified individuals under government policies. Additionally, 19 of the 57 Army attorneys who would be staffed under the plan would likely only serve in their positions for a

²⁰ According to Army officials, the Judge Advocates General's Corps has approximately 4,200 military and civilian attorneys and a significant portion of these can provide legal assistance to servicemembers. However, these officials also noted that these attorneys are not dedicated exclusively to the disability evaluation process and the extent to which these attorneys actually provide legal support to servicemembers during the disability evaluation process is unknown.

period of 12 to 18 months.²¹ According to a Disabled American Veterans representative with extensive experience counseling servicemembers during the evaluation process, frequent rotations and turnover of Army attorneys working on disability cases limits their effectiveness in representing servicemembers due to the complexity of disability evaluation regulations.

With respect to medical evaluation board physicians, who are responsible for documenting servicemembers medical conditions, the Army has mostly met its goal for the average number of servicemembers per physician at each treatment facility. In August 2007, the Army established a goal of one medical evaluation board physician for every 200 servicemembers.²² As with the staffing ratio for board liaisons, the ratio for physicians is reviewed every 90 days by the Army and the ratio at each treatment facility is reviewed weekly, according to an Army official. As of February 2008, the Army had met the goal of 200 servicemembers per physician at 29 of 35 treatment facilities and almost met the goal at two others.²³

Despite having mostly met its goal for medical evaluation board physicians, according to Army officials, the Army continues to face challenges in this area. For example, according to an Army official, physicians are having difficulty managing their caseload even at locations where they have met or are close to the Army's goal of 1 physician for 200 servicemembers due not only to the volume of cases but also their complexity. According to Army officials, disability cases often involve multiple conditions and may include complex conditions such as TBI and PTSD. Some Army physicians told us that the ratio of servicemembers per physician allows little buffer when there is a surge in caseloads at a treatment facility. For this reason, some physicians told us that the Army could provide better service to servicemembers if the number of servicemembers per physician was reduced from 200 to 100 or 150.

²¹These 19 are intended to be active duty attorneys. The Army intends to assign active duty attorneys to the disability evaluation process for a limited time period out of concern for the attorney to gain experience in other legal practice areas.

²²Although board physicians are part of the Warrior Transition Units, staffing targets for board physicians are based on the number of servicemembers in the disability evaluation process as opposed to the number of servicemembers in the Warrior Transition Units.

²³Two of the Army treatment facilities not meeting the 200 to 1 servicemember to physician ratio—Fort Riley, Kansas, and Fort Knox, Kentucky—each had a ratio of 201 to 1.

In addition to increasing the number of staff who support this process, the Army has reported other progress and efforts underway that could further ease the disability evaluation process. For example, the Army has reported improving outreach to servicemembers by establishing and conducting standardized briefings about the process. The Army has also improved guidance to servicemembers by developing and issuing a handbook on the disability evaluation process, and creating a web site for each servicemember to track his or her progress through the medical evaluation board. Finally, the Army told us that efforts are underway to further streamline the process for servicemembers and improve supporting information technology. For example, the Army established a goal to eliminate 50 percent of the forms required by the current process. While we are still assessing the scope, status, and potential impact of these efforts, a few questions have been raised about some of them. For example, according to Army officials, servicemembers' usage of the medical evaluation board web site has been low. In addition, some servicemembers with whom we spoke believe the information presented on the web site was not helpful in meeting their needs.

One measure of how well the disability evaluation system is working does not indicate that improvements have occurred. The Army collects data and regularly reports on the timeliness of the medical evaluation board process. While we have previously reported that the Army has few internal controls to ensure that these data were complete and accurate, the Army recently told us that they are taking steps to improve the reliability of these data.²⁴ We have not yet substantiated these assertions. Assuming current data are reliable, the Army has reported not meeting a key target for medical evaluation board timeliness and has even reported a negative trend in the last year. Specifically, the Army's target is for 80 percent of the medical evaluation board cases to be completed in 90 days or less, but the percent that met the standard declined from 70 percent in October through December 2006, to 63 percent in October through December 2007.

Another potential indicator of how well the disability evaluation process is working is under development. Since June 2007, the Army has used the Warrior Transition Program Satisfaction Survey to ask servicemembers about their experience with the disability evaluation process and board liaisons. However, according to Army officials in charge of the survey, response rates to survey questions related to the disability process were

²⁴GAO-06-362, p. 26.

particularly low because most surveyed servicemembers had not yet begun the disability evaluation process. The Army is in the process of developing satisfaction surveys that are separate from the Warrior Transition Unit survey to gauge servicemembers' perceptions of the medical and physical evaluation board processes.

DOD-VA Joint Disability Evaluation Process Pilot Geared Toward Quick Implementation, but Pilot Evaluation Plans Lack Key Elements

DOD and VA have joined together to quickly pilot a streamlined disability evaluation process, but evaluation plans currently lack key elements. In August 2007, DOD and VA conducted an intensive 5-day "table top" exercise to evaluate the relative merits of four potential pilot alternatives. Though the exercise yielded data quickly, there were trade-offs in the nature and extent of data that could be obtained in that time frame. In November 2007, DOD and VA jointly initiated a 1-year pilot in the Washington, D.C. area using live cases, although DOD and VA officials told us they may consider expanding the pilot to other locations beyond the current sites around July 2008. However, pilot results may be limited at that and other critical junctures, and pilot evaluation plans currently lack key elements, such as criteria for expanding the pilot.

Selection of Pilot Design Based on Formal but Quick 5-day Exercise

Prior to implementing the pilot in November 2007, the agencies conducted a 5-day "table top" exercise that involved a simulation of cases intended to test the relative merits of 4 pilot options. All the alternatives included a single VA rating to be used by both agencies. However, the exercise was designed to evaluate the relative merits of certain other key features, such as whether DOD or VA should conduct a single physical examination, and whether there should be a DOD-wide disability evaluation board, and if so, what its role would be. Ultimately, the exercise included four pilot alternatives involving different combinations of these features. Table 3 summarizes the pilot alternatives.

Table 3: Summary of Pilot Alternatives Considered by DOD and VA During August 2007 “Table Top” Exercise

	Comprehensive medical examination	Single disability rating done by VA	DOD-level evaluation board
Alternative 1	None. Separate DOD and VA examinations	Yes	Makes fitness determinations.
Alternative 2 ^a	Done by VA	Yes	None. Services make fitness determinations.
Alternative 3	None. Separate DOD and VA examinations	Yes	Adjudicates appeals of services’ fitness determinations.
Alternative 4	None. Separate DOD and VA examinations	Yes	Conducts quality assurance reviews of services’ fitness determinations.

Source: GAO analysis of information provided by DOD.

^aBased on the table top exercise, alternative 2 was selected for implementation.

The simulation exercise was formal in that it followed a pre-determined methodology and comprehensive in that it involved a number of stakeholders and captured a broad range of metrics. DOD and VA were assisted by consultants who provided data collection, analysis, and methodological support. The pre-determined methodology involved examining previously decided cases, to see how they would have been processed through each of the four pilot alternatives. The 33 selected cases intentionally reflected decisions originating from each of the military services and a broad range and number of medical conditions. Participants in the simulation exercise included officials from DOD, each military service, and VA who are involved in all aspects of the disability evaluation processes at both agencies. Metrics collected included case outcomes including the fitness decision, the DOD and VA ratings, and the median expected days to process cases. These outcomes were compared for each pilot alternative with actual outcomes. In addition, participants rank ordered their preference for each pilot alternative, and provided feedback on expected servicemember satisfaction as well as service and organization acceptance. They also provided their views on legislative and regulatory changes and resource requirements to implement alternative processes, and identified advantages and disadvantages of each alternative.

This table top exercise enabled DOD and VA to obtain sufficient information to support a near-term decision to implement the pilot, but it also required some trade-offs. For example, the intensity of the exercise—

simulating four pilot alternatives, involving more than 40 participants over a 5-day period—resulted in an examination of only a manageable number of cases. To ensure that the cases represented each military service and different numbers and types of potential medical conditions, a total of 33 cases were judgmentally selected by service: 8 Army, 9 Navy, 8 Marine, and 8 Air Force. However, the sample used in the simulation exercise was not statistically representative of each military service’s workload; as such it is possible that a larger and more representative sample could have yielded different outcomes. Also, expected servicemember satisfaction was based on the input of the DOD and VA officials participating in the pilot rather than actual input from the servicemembers themselves.

Based on the data from this exercise, the Senior Oversight Committee gave approval in October 2007 to proceed with piloting an alternative process with features that scored the highest in terms of participants’ preferential voting and projected servicemember satisfaction. These elements included a single VA rating (as provided in all the alternatives tested) and a comprehensive medical examination conducted by VA. The selected pilot design did not include a DOD-wide disability evaluation board.²⁵ Rather, the services’ physical evaluation boards would continue to determine fitness for duty, as called for under Alternative 2.

The Pilot Is Geared toward Quick Expansion, but Evaluation Plans Lack Key Elements

DOD and VA officials have described to us a plan for expanding the pilot that is geared toward quick implementation, but may have limited pilot results available to them at a key juncture. With respect to time frames, the pilot, which began in November 2007, is scheduled to last 1 year, through November 2008. However, prior to that date, planners have expressed interest in expanding the pilot outside the Washington metropolitan area. Pilot planners have told us that around July 2008—which is not long after the first report on the pilot is due to Congress²⁶—they may ask the Senior Oversight Committee to decide on expansion to more locations based on data available at that time. They suggested that a few additional locations would allow them to collect additional experience

²⁵The DOD Disability Advisory Council will conduct a quality control review of some service physical evaluation board decisions.

²⁶Pursuant to the National Defense Authorization Act for Fiscal Year 2008, enacted January 28, 2008, the Secretary of Defense must submit an initial report on the pilot within 90 days after enactment. The report is to include a description of the pilot program’s scope and objectives and the methodology to be used to achieve the objectives. Pub. L. No. 110-181, §1644(g).

and data outside the Washington, D.C. area before decisions on broader expansion are made. According to DOD and VA officials, time frames for national expansion have not yet been decided. However, DOD also faces deadlines for providing Congress an interim report on the pilot's status as early as October 2008, and for issuing a final report.²⁷

While expanding the pilot outside the Washington, D.C. area will likely yield useful information to pilot planners, due to the time needed to fully process cases, planners may have limited pilot results available to guide their decision making. As of February 17, 2008, 181 cases were currently in the pilot process, but none had completed the process. After conducting the simulation exercise, pilot planners set a goal of 275 days (about 9 months) for a case to go through the entire joint disability evaluation process. If the goal is an accurate predictor of time frames, potentially very few cases will have made it through the entire pilot process by the time planners seek to expand the pilot beyond the Washington area. As a result, DOD and VA are accepting some level of risk by expanding the pilot solely on the basis of early pilot results.

In addition to having limited information at this key juncture, pilot planners have yet to designate criteria for moving forward with pilot expansion and have not yet selected a comparison group to identify differences between pilot cases and cases processed under the current system, to allow for assessment of pilot performance. DOD and VA are collecting data on decision times and rating percentages, but have not identified how much improvement in timeliness or consistency would justify expanding the pilot process. Further, pilot planners have not laid out an approach for measuring the pilot's performance on key metrics—including timeliness and accuracy of decisions—against the current process. Selection of the comparison group cases is a significant decision, because it will help DOD and VA determine the pilot's impact, compared with the current process, and help planners identify needed corrections and manage for success. An appropriate comparison group might include servicemembers with a similar demographic and disability profile. Not having an appropriate comparison group increases the risk that DOD and

²⁷Under section 1644(g), the interim report must be submitted no later than 180 days after the date of the submittal of the initial report. Not later than 90 days after the completion of all of the pilot programs carried out under the act, the Secretary of Defense must submit a report setting out a final evaluation and assessment of the pilot programs. The final report is to include any recommendations for legislative or administrative action that the Secretary considers appropriate in light of the pilot programs.

VA will not identify problem areas or issues that could limit the effectiveness of any redesigned disability process. Pilot officials stated that they intend to identify a comparison group of non-pilot disability evaluation cases, but have not yet done so.

Another key element lacking from current evaluation plans is an approach for surveying and measuring satisfaction of servicemembers and veterans with the pilot process. As noted previously, several high-level commissions identified servicemember confusion over the current disability evaluation system as a significant problem. Pilot planners told us that they intend to develop a customer satisfaction survey and use customer satisfaction data as part of their evaluation of pilot performance but, as of February 2008, the survey was still under development. Even after the survey has been developed, results will take some time to collect and may be limited at key junctures because the survey needs to be administered after servicemembers and veterans have completed the pilot process. Without data on servicemember satisfaction, the agencies cannot know whether or the extent to which the pilot they are implementing has been successful at reducing servicemember confusion and distrust over the current process.

Concluding Observations

Over the past year, the Army has made substantial progress toward improving care for its servicemembers. After problems were disclosed at Walter Reed in early 2007, senior Army officials assessed the situation and have since dedicated significant resources—including more than 2,000 personnel—and attention to improve this important mission. Today, the Army has established Warrior Transition Units at its major medical facilities and doctors, nurses, and fellow servicemembers at these units are at work helping wounded, injured, and ill servicemembers through what is often a difficult healing process. Some challenges remain, such as filling all the Warrior Transition Unit personnel slots in a competitive market for medical personnel, lessening reliance on borrowed personnel to fill slots temporarily, and getting servicemembers eligible for Warrior Transition Unit services into those units. Overall, the Army is to be commended for its efforts thus far; however, sustained attention to remaining challenges and reliable data to track progress will be important to sustaining gains over time.

For those servicemembers whose military service was cut short due to illness or injury, the disability evaluation is an extremely important issue because it affects their service retention or discharge and whether they receive DOD benefits such as retirement pay and health care coverage. Once they become veterans, it affects the cash compensation and other

disability benefits they may receive from VA. Going through two complex disability evaluation processes can be difficult and frustrating for servicemembers and veterans. Delayed decisions, confusing policies, and the perception that DOD and VA disability ratings result in inequitable outcomes have eroded the credibility of the system. The Army has taken steps to increase the number of staff that can help servicemembers navigate its process, but is challenged to meet stated goals. Moreover, even if the Army is able to overcome challenges and sufficiently ramp up staff levels, these efforts will not address the systemic problem of having two consecutive evaluation systems that can lead to different outcomes.

Considering the significance of the problems identified, DOD and VA are moving forward quickly to implement a streamlined disability evaluation that has potential for reducing the time it takes to receive a decision from both agencies, improving consistency of evaluations for individual conditions, and simplifying the overall process for servicemembers and veterans. At the same time, DOD and VA are incurring some risk with this approach because the cases used were not necessarily representative of actual workloads. Incurring some level of risk is appropriate and perhaps prudent in this current environment; however, planners should be transparent about that risk. For example, to date, planners have not yet articulated in their planning documents the extent of data that will be available at key junctures, and the criteria they will use in deciding to expand the pilot beyond the Washington, D.C. area. More importantly, decisions to expand beyond the few sites currently contemplated should occur in conjunction with an evaluation plan that includes, at minimum, a sound approach for measuring the pilot's performance against the current process and for measuring servicemembers' and veterans' satisfaction with the piloted process. Failure to properly assess the pilot before significant expansion could potentially jeopardize the systems' successful transformation.

Mr. Chairman, this completes our prepared remarks. We would be happy to respond to any questions you or other Members of the Subcommittee may have at this time.

For further information about this testimony, please contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov, or John H. Pendleton at (202) 512-7114 or pendletonj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made major contributions to this testimony are listed in appendix I.

Appendix I: GAO Contacts and Staff Acknowledgments

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Acknowledgments

In addition to the contacts named above, Bonnie Anderson, Assistant Director; Michele Grgich, Assistant Director; Janina Austin; Susannah Compton; Cindy Gilbert; Joel Green; Christopher Langford; Bryan Rogowski; Chan My Sondhelm; Walter Vance; and Greg Whitney, made key contributions to this statement.

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